MINNESOTA LIFE

PREFERENCE BENEFICIARY'S STATEMENT

Group Division Claims • P.O. Box 64114 • St. Paul, MN 55164-0114 • FOR CLAIM INFORMATION CALL: Toll Free 1-800 328-9442 - MN local 651-665-3815

LEGAL NAME OF DECEASED INSURED (Last, First, Middle Initial)	DATE OF BIRTH (Mo/Day/Yr)	DATE OF DEATH (Mo/Day/Yr)

INSTRUCTIONS: The proceeds of insurance under this policy are payable to the beneficiary named by the insured. If the insured did not name a beneficiary, or if no designated beneficiary survived the insured, then this form is to be completed by the appropriate preference beneficiary as indicated. Submit this form and a certified copy of the death certificate to the Insurance Company. The Attending Physician's Statement on the reverse side of this form may be used in lieu of a certified copy of the death certificate.

CLAIM NUMBER

CHECK THE APPROPRIATE BOX AND GIVE YOUR NAME, ADDRESS, DATE OF BIRTH, SOCIAL SECURITY NUMBER AND DAYTIME TELEPHONE NUMBER BELOW:

- ☐ I am the surviving lawful wife or husband of the insured.
- ☐ I am a child of the insured. The insured left no surviving lawful wife or husband. The surviving lawful bodily and legally adopted children of the insured are myself and those listed below. Certified letters of guardianship for the estate of the minor child are needed for any minor beneficiaries (Complete a separate section below for **each** child).
- ☐ I am a parent of the insured. The insured left no surviving lawful wife or husband or lawful bodily or legally adopted child (Both parents must complete the section below. If one parent is deceased, please give date of death).
- ☐ I am the duly appointed representative of the insured's estate (executor or administrator). The insured left no surviving lawful wife or husband, lawful bodily or legally adopted child, or parent. **A certified copy of the Letters of Administration is attached. Please provide the estate's tax identification number in the social security box.**

NAME (Last, First, Middle Initial)	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER
ADDRESS (Street, City, State, Zip)		DAYTIME TELEPHONE NUMBER ( )
DATE SIGNED	SIGNATURE X	
NAME (Last, First, Middle Initial)	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER
ADDRESS (Street, City, State, Zip)		DAYTIME TELEPHONE NUMBER ( )
DATE SIGNED	SIGNATURE X	
NAME (Last, First, Middle Initial)	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER
ADDRESS (Street, City, State, Zip)		DAYTIME TELEPHONE NUMBER ( )
DATE SIGNED	SIGNATURE X	
NAME (Last, First, Middle Initial)	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER
ADDRESS (Street, City, State, Zip)		DAYTIME TELEPHONE NUMBER ( )
DATE SIGNED	SIGNATURE X	

CERTIFICATION – Under Penalties of perjury, I certify that:

(1) The number shown on this form is my correct Social Security Number or Taxpayer Identification Number, **and**

(2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, **and**

(3) I am a U. S. person (including a U. S. resident alien).

CERTIFICATION INSTRUCTIONS: You must cross out item (2) above if you have been notified by IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by the IRS that you were subject to backup withholding you received another notification from the IRS that you are no longer subject to backup withholding, do not cross out item (2).

Certification Notice:
THE IRS REQUIRES US TO OBTAIN CERTIFICATION OF YOUR SOCIAL SECURITY NUMBER OR TAXPAYER IDENTIFICATION NUMBER. WITHOUT THIS INFORMATION, YOU MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING FOR ANY INTEREST PAID ON THE DEATH BENEFIT.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

PHYSICIAN'S STATEMENT

1. Full Name of Deceased

Residence at Death

Date of Death Age at Death

Place of Death

(If hospital or institution, give name)

2. Cause of Death

Enter only one cause per line for (A), (B) and (C).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

Disease or Condition Directly Leading to Death*

(A) _____

Antecedent Causes
Morbid conditions, if any, giving rise to the above cause (A) stating the underlying cause last.

Due to (B) _____

Due to (C) _____

Interval between Onset and Death

(A) _____

(B) _____

(C) _____

Other Significant Conditions
Conditions contributing to the death but not related to the disease or condition causing death.

3. Date of First Attendance in Last Illness

Date of Last Attendance in Last Illness

4. If Death was due to accident, suicide, or homicide, specify which. Describe Briefly.

Was an inquest held? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No
If so, by whom and with what findings?

5. Have you treated or advised the deceased during the last 5 years prior to the last illness? ☐ Yes ☐ No
Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in any hospital or institution? ☐ Yes ☐ No
If yes to either question, please furnish the following:

NAME	ADDRESS	NATURE OF ILLNESS OR INJURY	DATES

These statements are true and complete to the best of my knowledge and belief.

_____ M.D.
(Signature)

_____
(Date)

_____
(Address)

A graduate of _____ Year _____

To the physician:
Please conform as closely as possible to the International List of Causes of Death. If the case falls in the class of violent or accidental death, please give details and describe how injury was received. If suicide or homicide, state the means employed. In surgical cases, state the nature of the operation and of the disease or condition which required such procedure. In females, puerperal states are to be indicated, if involved. In neoplasms, give type and part first involved. Please avoid indefinite terms. Describe any unusual features and amplify sufficiently to make the case clear.